# Health Committee: Public Expenditure Inquiry 2012

Key Points

- Economic modelling commissioned from the Institute for Fiscal Studies suggests that after the next spending review the NHS should not expect spending growth to return to the levels seen before the financial crisis or the long-run average.
- At best, spending may rise in line with growth in national income. Real and rapid productivity increases are therefore crucial. Such increases are unprecedented and it is by no means guaranteed that the NHS will be able to deliver them. We recommend several priorities be pursued.
- First are the incentive mechanisms built into the system of provider payment in the NHS (this includes hospitals and GPs). It is vital that managers within the NHS have a clear understanding of what their costs are; how they vary between trusts; and the extent to which payments match efficient costs, particularly as the Health and Social Care Act 2012 seeks to introduce a more transparent system of payments and subsidy brokerage.
- Second is the productivity and quality of primary health care; a neglected topic in the 2011/12 Operating Framework. Locally, there are reports of large cuts to local enhanced services (LES) contracts, many of which appear to be ad hoc and cost driven. Primary care will be a key component of any drive to deliver more coordinated care in the community and the identification of savings needs a careful, evidence-led approach.
- Third, the NHS Trust Development Authority is responsible for getting NHS trusts ready for foundation status. In seeking to place them on a sustainable footing, the key step is a proper understanding of why these

*Consultation response*

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organisations are financially challenged. Careful analysis is required, even if they lead to counterintuitive outcomes.

- While foundation trusts have substantially increased their delivery of cost improvement plans, they still remain below the estimated efficiency requirement. We share Monitor's scepticism about CCGs proving more successful at shifting activity out of hospitals than PCTs in their early years, and would query foundation trusts' optimistic assumptions in this regard.
- In addition to the £2 billion already set aside for social care, the Nuffield Trust has previously argued that commissioners should use some of their under-spends to protect and extend eligibility for social care services and to support preventative work. However, the evidence is not clear cut and it is therefore very important that, alongside short-term action of this kind, there is new analysis that increases our understanding of the potential benefits and risks that shifting resources between health and social care might bring.
- The Audit Commission's analysis of the financial year shows that 2011/12 PCTs, SHAs and NHS trusts generated a combined surplus of £1.6 billion with an additional £0.4 billion surplus in NHS foundation trusts. In addition, there was a substantial amount of non-recurrent spending by PCTs (£1.6 billion). The Audit Commission describes this as meaning that 'the NHS has a war chest approaching £4 billion (4 per cent of revenue)'. Although this does not appear to have led to measurable lapses in quality, the reasons for these resources not being spent, as well as future usage, are unclear.

We welcome the Health Committee's return to this important topic. Economic modelling commissioned from the Institute for Fiscal Studies suggests that after the next spending review the NHS should not expect spending growth to return to the levels seen before the financial crisis or the long-run average. At best, spending may rise in line with growth in national income. Real and rapid productivity increases are therefore crucial. Such increases are unprecedented and it is by no means guaranteed that the NHS will be able to deliver them. We recommend several priorities be pursued.

## The plans being made by NHS bodies to enable them to meet the Nicholson Challenge

The 2011/12 NHS Operating Framework set out a number of proposals intended to help the service save £20 billion from revenue budgets. These included:

- giving the NHS an additional year to achieve the QIPP challenge – from 2014, to March 2015
- cutting the NHS tariff by 1.5 per cent in cash terms in 2011/12 compared with 2010/11
- applying the same funding cut to services not covered by the tariff
- limiting the number of bed-days funded for some procedures
- extending the management costs reduction target to encompass 'running costs'
- top-slicing funding from PCTs to cover the costs of transition, and requiring business cases for this from April 2011 (Department of Health, 2010).

Several issues merit further scrutiny.

First is the growing importance of the incentives in the provider payment systems. The Audit Commission's 2010 *More for Less 2009/10* report showed that that, over the previous three years, income from non-tariff activity in NHS trusts grew by some 45 per cent; significantly more than income from tariff-based activity (Audit Commission, 2010). Collectively, this implied non-tariff growth across acute trusts of about £4 billion. Further analysis by the Audit Commission in 2011 led it to conclude that the non-tariff growth had not been due to an obvious increase in activity or costs, implying two possible causes (Audit Commission, 2011). Either prices for non-tariff services were higher than costs and commissioners had effectively used non-tariff income to cross-subsidise their providers, or some non-tariff costs were inbuilt into tariff activities and these were showing rapid growth (for instance high-cost drugs that would be excluded from PbR (Payment by Results) HRGs (Healthcare Resource Groups), but which would then be reimbursed by commissioners).

In an attempt to curtail the growth of non-tariff income, the 2011/12 Operating Framework specified that the 1.5 per cent reduction to tariff must also apply to non-tariff services This was a very welcome development, but improving efficiency and productivity in those services not covered by tariff must be a priority given the very rapid growth in spending over recent years.

A recent report by the Nuffield Trust investigating the use of patient-level information costing systems (PLICS) at one NHS trust also demonstrated the wide, and in some

cases consistent, variations between actual costs and tariff prices between HRGs. For example, only 17 per cent of tariff-chargeable cases at the example hospital trust incurred costs within 10 per cent of their tariff price; suggesting scope for a much deeper understanding of costs within hospital trusts, which could mean savings both at a micro and macro level (Nuffield Trust, 2012a).

In the context of the Health and Social Care Act, which seeks to introduce a more transparent system of payments and subsidy brokerage, it is important that there is much more clarity about the extent to which payments match efficient costs and managers are able to measure and challenge variation in treatment costs for ostensibly similar patients. Progress towards implementing PLICS throughout the NHS has been reasonably good so far, although there are ways to both accelerate its take up and use the data more fully within trusts (Department of Health, 2011). We also note that the increasing use of PLICS gives providers a major information advantage over commissioners and recommend that Monitor should consider mandating data sharing between commissioners and providers to ensure the integrity of the internal market.

Second, it is unrealistic to imagine that the overall efficiency challenge for the NHS can be met by acute sector productivity improvement and management cost savings alone. The second-largest area of health spend by commissioners is primary health care. Not only does it comprise 20 per cent of health care purchased by PCTs in 2009/10 (Audit Commission, 2011), but the quality of primary care also has a strong influence on the rate of avoidable admissions and acute hospital activity more generally.

However, the Operating Framework said very little about productivity in this area. We note that the Secretary of State's July 2012 letter to the Doctors and Dentists' Review Body (DDRB) hinted that further 'quality and efficiency gains' might also be needed of GPs this year. This is welcome, but it needs to be part of a well thought out strategy. Locally, there are reports of large cuts to LES (local enhanced services) contracts, but many of these appear ad hoc and cost-driven(Pulse, 2011). Primary care will be a key component of any drive to deliver more coordinated care in the community and the identification of savings needs a careful, evidence-led approach.

## Where changes are being proposed, and whether the NHS is succeeding in making efficiency gains rather than cuts

A comprehensive answer is not possible at this stage. What is known is that the out-turn for the NHS in 2011/12 was (without generating major obvious lapses in quality) £2 billion in unspent resource and almost the same amount of non-recurrent spending. Much of the NHS under-spend arises from DH and SHA requirements for PCTs and providers to plan to under-spend in year. It is important that the 'saved' resources are ploughed back into service transformation and improvement initiatives. We are not clear how much of the 'war chest' described by the Audit Commission Treasury has agreed will be available for reinvestment in 2012/13 (Audit Commission, 2012).

As to the question of efficiency gains rather than cuts, the absence of robust, publicly available information about savings makes it difficult to judge. SHA 'QIPP tracker' plans obtained by the *Health Service Journal* under freedom of information legislation suggest that many regions *are* grappling with the service transformation challenge (HSJ, 2012). Re-designs to care pathways for long-term conditions commonly feature. However, few areas appear to be contemplating larger scale reconfigurations. The quality of these data has not been validated, but the lack of large-scale changes seems reasonable given the lack of explicit instructions in the 2011/12 Operating Framework to proceed with essential reconfiguration of services, in particular with regard to hospitals.

The absence of planning around investment and major redesign is worrying. The QIPP timeline, as explained by David Nicholson, deliberately 'front loaded' centrally enacted measures, with the emphasis then expected to shift towards service transformation in the latter half of the spending review period, once the foundations had been laid. With wage growth across the economy currently low and unemployment high, the NHS is not encountering significant recruitment and retention problems. However, by 2015/16, the economy is expected to be growing and the Office for Budget Responsibility forecasts that average earnings across the economy will be increasing by 4.5 per cent. Holding down public sector pay against this background would be very difficult, underlining the need for real and rapid productivity growth in the interim.

This message is further reinforced by the economic modelling that we commissioned from the Institute for Fiscal Studies, which suggested that after the next spending review, the NHS may at best be able to expect spending to rise in line with growth in national income, substantially below the historic growth rates in NHS funding (Institute for Fiscal Studies, 2012).

Progress against productivity targets also cannot be meaningfully judged without a clearer concept of quality. As research by Professor Nick Black has shown, traditional measures of NHS productivity can be problematic, with gains in evidence-based practice, patient outcomes, and patient experiences potentially obscured (Black, 2012). Conversely, 'top level' quality indicators can fail to track a decline in patient outcomes during periods when crude productivity increases.

To fill this gap, the Nuffield Trust has recently launched a new surveillance project with funding from the Health Foundation. Our plan is to develop credible sets of indicators to measure changes in efficiency and quality (broadly defined as access, safety, equity, effective care, patient reported outcomes and experience). These will be used to track change over time across areas within England, and in comparison with other countries where possible. Such work will use existing sources of data, and may commission new sources. Building on the Nuffield Trust's capacity to use complex information, we will bring new perspectives on how the quality of care is changing within the NHS and we will also drill down into specific topics. Examples of this include changes in the quality of primary/outpatient/community care by tracking rates of avoidable admission. The work is at an early stage, but we expect to be able to report initial findings to the Committee next (calendar) year.

## The prospects for the long-term viability of NHS trusts and NHS foundation trusts given (a) the 2010 spending review settlement and (b) financial commitments incurred under the Private Finance Initiative (PFI)

The latest financial data confirm the growing strength of the commissioning sector as risk is increasingly transferred to providers through changes to the payment system (Audit Commission, 2012). We agree that reducing avoidable emergency admissions should be a core target for PCT clusters and GP commissioners. But for this work, there needs to be investment in admission avoidance schemes and careful cooperation between commissioners and providers (Nuffield Trust, 2011a). Foundation Trust Network survey data showing commissioner apathy in this regard are therefore a concern (Foundation Trust Network, 2012).

While foundation trusts have substantially increased their delivery of cost improvement plans (CIP), they still remain below the estimated efficiency requirement. We share Monitor's scepticism about CCGs proving more successful at shifting activity out of hospitals than PCTs in their early years, and would query foundation trusts' optimistic assumptions in this regard (Monitor, 2012). Rather, the evidence suggests that as the scope for further CIP savings declines, providers will need to continue to work hard with their commissioners, their clinical teams and each other to deliver strategic measures, including system reconfiguration and consolidation of suppliers, to be in a strong position by 2015 (Nuffield Trust, 2012b).

On this latter point, we wish to warn against the trend towards mergers as the *automatic* solution to an organisation's financial ills. The research evidence shows that scale does matter in health care – for both quality and cost – but these benefits may not be continuous. For instance, a recent Nuffield Trust evidence review concluded that cost per case falls as a hospital's size increases to 200 beds; remains roughly constant until about 600 beds; above which diseconomies begin to appear (Nuffield Trust, 2012a). Many of the NHS trusts contemplating mergers would result in organisations with 600-plus beds.

The studies reviewed by the Nuffield Trust did not examine quality and it may be that quality gains from scale are sufficient to offset the increased cost. However, economists at Bristol have raised further doubts about the benefit of mergers. In a widely-reported paper, Gaynor and others looked at the impact of the 102 NHS hospital mergers which occurred between 1997 and 2006 (Gaynor and others, 2012). Although admissions, staff numbers and beds fell by an average of 11-12 per cent a year, operating expenditure did not fall at the same rate and mergers did not stem the increasing size of hospital deficits. Crucially, they found *no* significant improvement in productivity or quality attributable to mergers, and waiting times also rose.

The NHS Trust Development Authority is responsible for getting NHS trusts ready for foundation status. In seeking to place them on a sustainable footing, the key step is a proper understanding of why these organisations are financially challenged. If it is because they are too small to be viable financially or clinically, a merger may deliver better outcomes for patients and taxpayers. But if size is not the problem and the issue lies in wider health economy problems, or transforming efficiency through clinical leadership, then increasing the size of the organisation is unlikely to deliver.

Careful analysis is required, even if it leads to counterintuitive results. For example, we note the increasing concern over the effect of PFI deals. However, forthcoming research from the Nuffield Trust that analyses high performing and poor performing health economies will suggest that other factors (particularly around resource allocation) play a more important role in financial performance (Nuffield Trust, forthcoming).

## The impact on the provision of adult social care of the 2010 spending review settlement

Overall, local government spending on non-ring-fenced services (which includes social care but excludes schools, fire and the police) is projected to fall by 14 per cent in real terms by 2014/15 (House of Commons Health Committee, 2012). The government has attempted to mitigate this fall by directing additional funds towards social care, but it is unlikely to be enough.

With increasing productivity also unlikely to provide a solution, local authorities have systematically been reducing access to care. In 2005/06, 62 per cent of local authorities had restricted their eligibility threshold for publicly-funded social care to 'substantial' or 'critical' levels of need. In 2007/08, this had increased to 72 per cent (Commission for Social Care Inspection, 2008), and by 2011/12 to 82 per cent (Association of Directors of Adult Social Services, 2011). Between 2005 and 2010, the number of working-age adults (18 to 64-year-olds) using social care services rose by almost 12 per cent, but the number of older people being supported fell by almost 7 per cent (Humphries, 2011).

Pressure on funding may also be impacting on quality of the services themselves, although the evidence is limited. Research funded by the Joseph Rowntree Foundation found that in most cases the fees paid by local authorities to care homes are too low to achieve the National Minimum Standards of Quality (Laing, 2008).

## The impact on NHS plans of decisions currently being made by local authorities

There is growing evidence of a clear connection between the intensity and quality of social care, and the use of NHS services. Research has found that in parts of the country where local authorities' spending on social care per head for the over-65s is lower, there were more delayed discharges from NHS hospitals and more emergency readmissions (Fernandez and Forder, 2008).

However, more work is needed to understand what types of social care lead to a reduction in avoidable admissions and better outcomes for patients. For instance, recent analysis by the Nuffield Trust of data on users of health and social care found that residents of residential care homes had fewer hospital admissions than their counterparts being cared for at home (Bardsley and others, 2012); a finding later confirmed in a major study of social care at the end of life (Nuffield Trust, 2012c).

## The use of the additional funding for social care being made available through the NHS budget

It is not clear that the differential rate of growth between the NHS and social care has delivered the most cost-effective mix of services, particularly for very elderly people with complex health and care needs who receive support from both the NHS and social care providers. In addition to the £2 billion set aside for social care, the Nuffield Trust has argued that commissioners should use some of their under-spends to protect and extend eligibility and support preventative work, with a recommendation that transfers focus on social care programmes that offer both potential benefit to service users and efficiency gains for health and social care.

However, it must be emphasised that the evidence is not clear-cut: attempts to invest in enhanced, preventative social services at the patient or community level have often not delivered the anticipated level of savings (Nuffield Trust, 2011b). It is therefore very important that, alongside short-term action of this kind, there is new analysis that increases our understanding of the potential benefits and risks that shifting resources between health and social care might bring. In particular, the Department of Health may wish to consider a review of the optimal balance between health and social care funding ahead of the next spending review.

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